The Royal **Children's** Hospital Melbourne

UR NUMBER

SURNAME

GIVEN NAME(S)

DATE OF BIRTH

AFFIX PATIENT LABEL HERE ↑

Neurodiagnostics Request

Specialist Clinics
Ground Floor, Reception A3
Telephone 9345 6180 Facsimile 9345 5034

ADDRESS

POSTCODE

Outpatient Services Ext 56180
◯ Routine EEG ◯ Sleep deprived EEG

Inpatient services Ext 55602
◯ NCS/EMG ◯ SSEP ◯ Spinal Monitoring ◯ Other _____

History/Provisional diagnosis

Additional Patient information
◯ Standard patient ◯ Complex patient
◯ Behavioural
◯ Developmental
◯ Autism
◯ Other _____

Current medications

Time and date of last event _____ : _____ / _____ /20 _____

Did the event occur from sleep? ◯ Yes ◯ No

If yes then a sleep deprived EEG is recommended

Referred by *Print name* _____

Contact information _____

_____

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